

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES (HFS)  
PRIOR AUTHORIZATION REQUEST FORM  
SEROQUEL OR ZYPREXA

**A. PHYSICIAN INFORMATION - Complete ALL Information Below:**

Physician Name: \_\_\_\_\_ Attending Physician's DEA #: \_\_\_\_\_ License #: \_\_\_\_\_

Is Prescriber a Psychiatrist? Yes ☐ No ☐ If not, list specialty. \_\_\_\_\_ Office Phone #: \_\_\_\_\_

**B. PHARMACY INFORMATION - Complete ALL Information Below:**

Pharmacy Name: \_\_\_\_\_ Pharmacy ID: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_

**C. PATIENT INFORMATION - Complete ALL Information Below:**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Patient 9 Digit IDHFS Recipient Number: \_\_\_\_\_

List All Relevant Diagnoses: \_\_\_\_\_ ICD-9 Codes: \_\_\_\_\_

Patient is developmentally disabled? Yes ☐ No ☐ Patient is discharged from a state mental health facility? Yes ☐ No ☐

**D. NON-PREFERRED MEDICATION JUSTIFICATION Complete ALL Information Below:**

Prior Authorization Requested for: Seroquel (Quetiapine) ☐ Zyprexa (Olanzapine) ☐

Patient is already established on drug being requested ☐ New request - patient is not already established on drug being requested ☐

If established, start date of therapy on drug being requested ☐

Dose\* and Dosing Schedule Requested: \_\_\_\_\_

\*minimum/maximum dose: Quetiapine = 200mg/900mg divided; Olanzapine = 2.5mg/30mg once per day

Agents Previously Utilized:	Maximum Dose Utilized:	Length of Therapy:	Result of Trial:
Abilify (aripiprazole) <input type="checkbox"/>	_____	_____	_____
Clozaril (clozapine) <input type="checkbox"/>	_____	_____	_____
Geodon (ziprazidone) <input type="checkbox"/>	_____	_____	_____
Zyprexa (olanzapine) <input type="checkbox"/>	_____	_____	_____
Risperdal (risperidone) <input type="checkbox"/>	_____	_____	_____
Seroquel (quetiapine) <input type="checkbox"/>	_____	_____	_____

**E. ADDITIONAL INFORMATION - Please include any relevant information you wish to be considered during review.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IMPORTANT: To prevent delay, fax relevant patient information with this form to validate request.**

**F. PHYSICIAN OR DESIGNEE SIGNATURE**

\_\_\_\_\_  
Signature Date

PLEASE COMPLETE ALL INFORMATION TO ENSURE PROMPT PROCESSING.

N 10/3/2005

FAX TO 866-327-2070 (Toll-Free)

ATTN: MEDICAL COMMITTEE